

Kansas Medical Assistance Programs

Provider Line: 1-800-933-6593
Consumer Line: 1-800-766-9012

P.O. Box 3571, Topeka KS 66601-3571
Prior Authorization: 1-800-285-4978 or 785-274-5499
Prior Authorization Fax Lines: 1-800-913-2229 or 785-274-5956

SYNAGIS AUTHORIZATION FORM

Consumer Name: _____

Consumer Medicaid ID #: _____ Date Of Birth: ____/____/____ Current Age: _____

Pharmacy Name: _____ Provider Medicaid ID#: _____

Phone Number: (____) _____ Fax Number: (____) _____

Drug Name: _____ NDC Requested: _____

- OR -

Prescribing Physicians Name: _____ Provider Medicaid ID#: _____

Phone Number: (____) _____ Fax Number: (____) _____

Procedure code requesting: _____ Total # of units requesting: _____

Please indicate billing name/number if different from the pharmacy or physician information above:

Billing Provider Name: _____ Billing Medicaid Provider ID#: _____

In order to determine medical necessity, please complete the following:

1. Child's gestational age at birth: _____

2. Does the child have chronic lung disease? _____ (If yes, please indicate treatment(s), date(s) and diagnosis for the past 6 months:

3. Please indicate if the child has any of the following risk factors:

- ☐ underlying condition predisposing him/her to respiratory complications
(if yes, please indicate what: _____)
- ☐ young siblings in the home
- ☐ childcare center attendance
- ☐ exposure to tobacco smoke in the home
- ☐ anticipated cardiac surgery
- ☐ other (please specify): _____

Child's current weight: _____

Signature of Ordering Physician or Designee: _____

Date of Request: ____/____/____

Completed form should be faxed to 1-800-913-2229.

This form will be returned unprocessed if it is not completed in its entirety. If a case has been started and the information requested is not received within 15 working days, the case will be denied.